Facility Services

This section contains payment policies and information for facility services.

All providers must follow the administrative rules, medical coverage decisions and payment policies contained within the *Medical Aid Rules and Fee Schedules*, Provider Bulletins and Provider Updates.

If there are any services, procedures or text contained in the CPT® and HCPCS coding books that are in conflict with the *Medical Aid Rules and Fee Schedules*, the department's rules and policies take precedence (see WAC 296-20-010).

All policies in this document apply to claimants receiving benefits from the State Fund, the Crime Victims Compensation Program and Self-Insurers unless otherwise noted.

Questions may be directed to the Provider Hotline at 1-800-848-0811 or to the Crime Victims Compensation Program at 1-800-762-3716.

FACILITY SERVICES TABLE OF CONTENTS

HOSPITAL PAYMENT POLICIES

HOSPITAL PAYMENT POLICIES OVERVIEW

Hospital payment policies established by the department are reflected in Chapters 296-20, 296-21, 296-23 and 296-23A WAC**,** Provider Bulletins 02-05 and 01-13, and the Hospital Billing Instructions.

L&I or Self-Insurers will pay for the costs of proper and necessary hospital services associated with an accepted industrial injury. No co-payments or deductibles are required or allowed from injured workers.

HOSPITAL BILLING REQUIREMENTS

All charges for hospital inpatient and outpatient services provided to injured workers must be submitted on the UB-92 billing form following the **UB-92 National Uniform Data Element Specifications.**

Hospitals are responsible for establishing criteria to define inpatient and outpatient services. All inpatient bills will be evaluated according to the department's Utilization Review Program. Inpatient bills submitted without a treatment authorization number may be selected for retrospective review.

For a current copy of the Hospital Billing Instructions, contact the Provider Hotline at 1-800-848-0811.

HOSPITAL INPATIENT PAYMENT INFORMATION

State Fund Payment Methods

Services for hospital inpatient care provided to injured workers covered by the State Fund are paid using three payment methods:

1. An All Patient Diagnosis Related Group (AP-DRG) system. See WAC 296-23A-0470 for exclusions and exceptions. The department currently uses AP-DRG Grouper version 14.1.
2. A statewide Per Diem rate for those AP-DRGs that have low volume or for inpatient services provided in Washington rural hospitals.
3. A Percent of Allowed Charges (POAC) for hospitals excluded from the AP-DRG system.

The following table provides a summary of how the above methods are applied.

Hospital Type or Location	Payment Method for Hospital Inpatient Services
Hospitals not in Washington	Paid by an Out-of-State POAC factor. Effective **July 1, 2004** the rate is **53.8%.**
Washington excluded Hospitals: • Children's Hospitals • Health Maintenance Organizations (HMOs) • Military Hospitals • Veterans Administration • State Psychiatric Facilities	Paid 100% of allowed charges.
• Washington Rural Hospitals [Department of Health (DOH) Peer Group 1]	Paid using Washington statewide per diem rates for designated AP-DRG categories: • Chemical dependency • Psychiatric • Rehabilitation • Medical • Surgical
All other Washington Hospitals	Paid on a per case basis for admissions falling within designated AP-DRGs.(1) For low volume AP-DRGs, Washington hospitals are paid using the statewide per diem rates for designated AP-DRG categories: • Chemical dependency • Psychiatric • Rehabilitation • Medical • Surgical

(1) See http://www.LNI.wa.gov/claimsinsurance/providerpay/feeschedules/default.asp for the current AP-DRG Assignment List.

Hospital Inpatient AP-DRG Base Rate

Effective **July 1, 2004** the AP-DRG Base Rate is **$ 7,539.66.**

Hospital Inpatient AP-DRG Per Diem Rates

Effective **July 1, 2004** the AP-DRG Per Diem Rates are as follows:

PAYMENT CATEGORY	RATE(1)	DEFINITION
Psychiatric AP-DRG Per Diem	**$ 912.61** Multiplied by the number of days allowed by the department. Payment will not exceed allowed billed charges.	AP-DRGs 424-432
Chemical Dependency AP-DRG Per Diem	**$ 696.50** Multiplied by the number of days allowed by the department. Payment will not exceed allowed billed charges.	AP-DRGs 743-751
Rehabilitation AP-DRG Per Diem	**$ 1,335.68** Multiplied by the number of days allowed by the department. Payment will not exceed allowed billed charges.	AP-DRG 462
Medical AP-DRG Per Diem	**$ 1,523.92** Multiplied by the number of days allowed by the department. Payment will not exceed allowed billed charges.	AP-DRGs identified as medical
Surgical AP-DRG Per Diem	**$ 2304.70** Multiplied by the number of days allowed by the department. Payment will not exceed allowed billed charges.	AP-DRGs identified as surgical

(1) For information on how specific rates are determined see Chapter 296-23A WAC in the *Medical Aid Rules and Fee Schedules.*

The AP-DRG Assignment List with AP-DRG codes and descriptions and length of stay is in the fee schedules section and is available online at http://www.LNI.wa.gov/claimsinsurance/providerpay/feeschedules/default.asp .

Additional Inpatient Hospital Rates

PAYMENT CATEGORY	RATE	DEFINITION
Transfer-out Cases	Unless the transferring hospital's charges qualify for low outlier status, the stay at this hospital is compared to the AP-DRGs average length of stay. If the patient's stay is less than the average length of stay, a per-day rate is established by dividing the AP-DRG payment amount by the average length of stay for the AP-DRG. Payment for the first day of service is two times the per-day rate. For subsequent allowed days, the basic per-day rate will be paid. If the patient's stay is equal to or greater than the average length of stay, the AP-DRG payment amount will be paid.	A transfer is defined as an admission to another acute care hospital within 7 days of a previous discharge.
Low Outlier Cases (costs are less than the threshold)	Hospital Specific POAC Factor multiplied by allowed billed charges.	Cases where the cost (1) of the stay is less than ten percent (10%) of the statewide AP-DRG rate or **$ 527.16**, whichever is greater.
High Outlier Cases (costs are greater than the threshold)	AP-DRG payment rate plus 100% of costs in excess of the threshold.	Cases where the cost (1) of the stay exceeds **$12,651.77** or two standard deviations above the statewide AP-DRG rate, whichever is greater.

(1) Costs are determined by multiplying the allowed billed charges by the hospital specific POAC factor.

Self-Insured Claims

Services for hospital inpatient care provided to injured workers covered by self-insured employers are paid using a hospital-specific POAC factor (see WAC 296-23A-0210).

Crime Victims Claims

Services for hospital inpatient care provided to crime victims covered by the Crime Victims Compensation Program are paid using Medicaid POAC factors (see WAC 296-30-090).

HOSPITAL OUTPATIENT PAYMENT INFORMATION

Services for hospital outpatient care provided to injured workers covered by the State Fund are paid using three payment methods:

1. Ambulatory Payment Classification (APC) system. See Chapter 296-23A WAC (Section 4) and Provider Bulletins 01-13 and 02-05 for a description of the department's APC system.
2. An amount established through the department's Professional Services Fee Schedule for items not covered by the APC system.
3. POAC for hospital outpatient services not paid by either the APC system or with an amount from the Professional Services Fee Schedule.

The following table provides a summary of how the above methods are applied.

Hospital Type or Location	Payment Method for Hospital Outpatient Services
Hospitals not in Washington State	Paid by an Out-of-State POAC factor. Effective **July 1, 2004** the rate is **53.8%.**
Washington Excluded Hospitals: • Children's Hospitals • Military Hospitals • Veterans Administration • State Psychiatric Facilities	Paid 100% of allowed charges
• Rehabilitation Hospitals • Cancer Hospitals • Rural Hospitals (DOH Peer Group 1) • Critical Access Hospitals • Private Psychiatric Facilities	Paid a facility-specific POAC
All other Washington Hospitals	Paid on a per APC (1) basis for services falling within designated APCs. For non-APC paid services, Washington hospitals are paid using an appropriate Professional Services Fee Schedule amount, or a facility-specific POAC(1).

(1) Hospitals will be sent their individual POAC and APC rate each year.

Hospital Outpatient Payment Process

Question	Answer	Payment Method
1. Does L&I cover the service?	No	Do Not Pay
	Yes	Go to question 2
2. Does the service coding pass the Outpatient Code Editor (OCE) edits?	No	Do Not Pay
	Yes	Go to question 3
3. Is the procedure on the inpatient-only list?	No	Go to question 4
	Yes	Pay POAC(1)
4. Is the service packaged?	No	Go to question 5
	Yes	Do Not Pay, but total the Costs for possible outlier(2) consideration. Go to question 7.
5. Is there a valid APC?	No	Go to question 6
	Yes	Pay the APC amount and total payments for outlier(2) consideration. Go to question 7.
6. Is the service listed in a Fee Schedule?	No	Pay POAC
	Yes	Pay the Facility Amount for the service
7. Does the service qualify for outlier?(1)	No	No outlier payment
	Yes	Pay outlier amount (3)

(1) If only 1 line item on the bill is IP, the entire bill will be paid POAC.
(2) Only services packaged or paid by APC are used to determine outlier payments.
(3) Outlier amount is in addition to regular APC payments.

Self-Insured Claims

Services for hospital outpatient care provided to injured workers covered by Self-Insured employers are paid using facility-specific POAC factors or the appropriate Professional Services Fee Schedule amounts (see WAC 296-23A-0221).

Crime Victims Claims

Services for hospital outpatient care provided to crime victims covered by the Crime Victims Compensation Program are paid using either Medicaid POAC factors or the Professional Services Fee Schedule amounts (see WAC 296-30-090).

AMBULATORY SURGERY CENTER (ASC) PAYMENT POLICIES

ASC GENERAL INFORMATION

Information about the department's requirements for ASCs can be found in Chapter 296-23B WAC, available online at http://www.LNI.wa.gov/ClaimsInsurance/Rules/default.asp and in Provider Bulletin 01-12, available online at http://www.LNI.wa.gov/ClaimsInsurance/Providers/ProviderBulletins/default.asp.

ASC SERVICES INCLUDED IN THE FACILITY PAYMENT

Facility payments for ASCs include the following services which are not paid separately:

- Nursing, technician and related services
- Use by the recipient of the facility including the operating room and the recovery room
- Drugs, biologics, surgical dressings, supplies, splints, casts and appliances and equipment directly related to the provision of surgical procedures
- Diagnostic or therapeutic services or items directly related to the provision of a surgical procedure
- Administration, record keeping and housekeeping items and services
- Intraocular lenses
- Materials for anesthesia
- Blood, blood plasma and platelets

ASC SERVICES NOT INCLUDED IN THE FACILITY PAYMENT

Facility payments for ASCs do not include the following services which are paid separately:

- Professional services including physicians
- Laboratory services
- X-Ray or diagnostic procedures other than those directly related to the performance of the surgical procedure
- Prosthetics and implants except intraocular lenses
- Ambulance services
- Leg, arm, back and neck braces
- Artificial limbs
- DME for use in the patient's home

ASC PROCEDURES COVERED FOR PAYMENT

The department will use the CMS list of procedures covered in an ASC plus additional procedures determined by the department. All procedures covered in an ASC are listed in the Provider Billing and Fees, Fee Schedules section available online at http://www.LNI.wa.gov/ClaimsInsurance/ProviderPay/FeeSchedules/default.asp.

The department expanded the list that CMS established for allowed procedures in an ASC. There are three areas where the list has been expanded:

1. L&I will cover surgical procedures that other Washington State agencies cover in ASCs and that meet L&I's coverage policies.
2. L&I will cover surgical procedures that CMS covers in its hospital outpatient prospective payment system (OPPS) that are not on the CMS ASC list and that meet L&I's coverage policies.
3. L&I will cover some procedures in an ASC that CMS covers only in an inpatient setting if both of the following criteria are met:
    a. The surgeon deems that it is safe and appropriate to perform such a procedure in an outpatient setting, and
    b. The procedure meets the department's utilization review requirements.

ASC PROCEDURES NOT COVERED FOR PAYMENT

Procedures that are not listed in the ASC fee schedule section of the *Medical Aid Rules and Fee Schedules* are not covered in an ASC.

ASCs will not receive payment for facility services for minor procedures that are commonly done in an office setting or treatment room. See the next paragraph for exceptions to this policy. The provider performing these procedures may still bill for the professional component.

Process to Obtain Approval for a Non-Covered Procedure

Under certain conditions, the director, the director's designee or Self-Insurer, at their sole discretion, may determine that a procedure not on the department's ASC procedure list may be authorized in an ASC. For example, this may occur when a procedure could be harmful to a particular patient unless performed in an ASC. Requests for coverage under these special circumstances require prior authorization.

The health care provider must submit a written request and obtain approval from the department or Self-Insurer prior to performing any procedure not on the ASC procedure list. The written request must contain a description of the proposed procedure with associated CPT® or HCPCS procedure codes, the reason for the request, the potential risks and expected benefits and the estimated cost of the procedure. The healthcare provider must provide any additional information about the procedure requested by the department or Self-Insurer.

ASC BILLING INFORMATION

Modifiers accepted for ASCs

-SG Ambulatory Surgical Center facility service

Modifier -SG may accompany all CPT® and HCPCS codes billed by an ASC. The department will accept modifiers listed in the CPT® and HCPCS books including those listed as approved for ASCs.

Modifiers affecting payment for ASCs

-50 Bilateral Modifier

Modifier -50 identifies cases where a procedure typically performed on one side of the body is performed on both sides of the body during the same operative session. Providers must bill using separate line items for each procedure performed. Modifier -50 must be applied to the second line item. The second line item will be paid at **50%** of the allowed amount for that procedure.

Example: Bilateral Procedure

Line item on bill	CPT® code/modifier	Maximum payment (Group 2)	Bilateral policy applied	Allowed amount
1	64721 -SG	$ 1,043.00		$ 1,043.00(1)
2	64721 -SG -50	$ 1,043.00	$ 521.50(2)	$ 521.50
Total allowed amount				$ **1,564.50**(3)

(1) First line item is paid at 100% of maximum allowed amount.
(2) When applying the bilateral payment policy the second line item billed with a modifier -50 is paid at 50% of the maximum allowed amount for that line item.
(3) Represents total allowable amount.

-51 Multiple surgery

Modifier -51 identifies when multiple surgeries are performed on the same patient at the same operative session. Providers must bill using separate line items for each procedure performed. Modifier -51 should be applied to the second line item. The total payment equals the sum of:

100% of the maximum allowable fee for the highest valued procedure according to the fee schedule, plus

50% of the maximum allowable fee for the subsequent procedures with the next highest values according to the fee schedule.

Example: Multiple Procedures

Line item on bill	CPT® code/modifier	Maximum payment (Groups 4 & 2)	Multiple policy applied	Allowed amount
1	29881 -SG	$ 1,473.00		$ 1,473.00(1)
2	64721 -SG -51	$ 1,043.00	$ 521.50(2)	$ 521.50
Total allowed amount				$ **1994.50**(3)

(1) Highest valued procedure is paid at 100% of maximum allowed amount.
(2) When applying the multiple procedure payment policy the second line item billed with a modifier -51 is paid at 50% of the maximum allowed amount for that line item.
(3) Represents total allowable amount.

If the same procedure is performed on multiple levels the provider must bill using separate line items for each level.

-73 Discontinued procedures prior to the administration of anesthesia

Modifier -73 is used when a physician cancels a surgical procedure due to the onset of medical complications subsequent to the patient's preparation, but prior to the administration of anesthesia. Payment will be at **50%** of the maximum allowable fee. Multiple and bilateral procedure pricing will apply to this, if applicable.

-74 Discontinued procedures after administration of anesthesia

Modifier -74 is used when a physician terminates a surgical procedure due to the onset of medical complications after the administration of anesthesia or after the procedure was started. Payment will be at **100%** of the maximum allowable fee. Multiple and bilateral procedure pricing will apply to this, if applicable.

-99 Multiple modifiers

Modifier -99 must be used when more than four modifiers affect payment. Payment is based on the policy associated with each individual modifier that describes the actual services performed. For billing purposes only modifier -99 must go in the modifier column, with the individual descriptive modifiers that affect payment listed in the remarks section of the billing form.

Exception: **Procedure Codes assigned to ASC Payment Groups 12 and 14**

CPT® and HCPCS codes assigned to ASC Payment Group 12 and ASC Payment Group 14 are not subject to multiple procedure discounting. A listing of the codes and payment groups are available online at http://www.LNI.wa.gov/ClaimsInsurance/ProviderPay/FeeSchedules/default.asp.

Prosthetic Implants

Implants must be billed on a separate line. The department covers HCPCS implant codes L8500 through L8699. ASCs will be paid acquisition cost for implants.

Exception: L8603

HCPCS code L8603 has a maximum fee and pays the lesser of the maximum fee or acquisition cost.

Exception: Intraocular Lenses

Intraocular lenses, including new technology lenses, are bundled into the fee for the associated procedure. Please include the cost of the lens in the charge for the procedure. It is permissible to include a line on the bill with the HCPCS code for an intraocular lens (i.e., V2630, V2631 and V2632) and its associated cost for information purposes only.

Acquisition Costs Policy

The acquisition cost equals the wholesale cost plus shipping, handling and sales tax. These items must be billed together as one charge. For taxable items, an itemized listing of the cost plus sales tax may be attached to the bill but is not required.

Wholesale invoices for all supplies and materials must be retained in the provider's office files for a minimum of five years. A provider must submit a hard copy of the wholesale invoice to the department or Self-Insurer when an individual supply costs $150.00 or more, or upon request. The insurer may delay payment of the provider's bill if the insurer has not received this information.

Example: Procedure with Implant

Line item on bill	CPT® code/modifier	Maximum payment (Group 4)	Allowed amount
1	29851 -SG	$ 1,473.00	$ 1,473.00(1)
2	L8699	$ 150.00 (Acquisition cost)	$ 150.00(2)
Total allowed amount			$ **1,623.00**(3)

(1) Procedure is paid at 100% of maximum allowed amount.
(2) Represents the total of wholesale implant cost plus associated shipping, handling and taxes.
(3) Represents total allowable amount.

Spinal Injections

Injection procedures are billed in the same manner as all other surgical procedures with the following considerations:

1. For purposes of multiple procedure discounting, each procedure in a bilateral set is considered to be a single procedure.
2. For injection procedures which require the use of radiographic localization and guidance, ASCs must bill for the technical component of the radiologic CPT® code (e.g., 76005 -TC) to be paid for the operation of a fluoroscope or C-arm.
3. Maximum fees for the technical components of the radiologic CPT® codes are listed in the radiology section of the Professional Services Fee Schedule available online at http://www.LNI.wa.gov/ClaimsInsurance/ProviderPay/FeeSchedules/default.asp.

Example: Injection Procedures

Line item on bill	CPT® code/modifier	Maximum payment (Group 1)	Bilateral/Multiple policies applied	Allowed amount
1	64470 -SG	$ 778.00		$ 778.00(1)
2	64470 -SG -50	$ 778.00	$ 389.00(2)	$ 389.00
3	64472 -SG	$ 778.00	$ 389.00(3)	$ 389.00
4	64472 -SG -50	$ 778.00	$ 389.00(2)	$ 389.00
5	76005 -TC	$ 69.87		$ 69.87(4)
Total allowed amount				$**2,014.87**(5)

(1) Highest valued procedure is paid at 100% of maximum allowed amount.
(2) When applying the bilateral procedure payment policy the second line item billed with a modifier -50 is paid at 50% of the maximum allowed amount for that line item.
(3) The multiple procedure payment policy is applied to subsequent procedures billed on the same day and are paid at 50% of the maximum allowed amount for that line item.
(4) This is the fee schedule maximum allowed amount for the fluoroscopic localization and guidance.
(5) Represents total allowable amount.

Exception: HCPCS Code G0260

G0260 cannot accept modifier -50 or any other multiple procedure modifier.

ASC PAYMENTS FOR SERVICES

The department pays the lesser of the billed charge (the ASC's usual and customary fee) or the department's maximum allowed rate.

The department's rates are based on a modified version of the grouping system developed by Medicare for ASC services. Medicare's grouping system was originally intended to group procedures with similar resource use together into payment categories. The department has modified Medicare's grouping system to fit a workers' compensation population.

Surgical services have been divided into 14 payment groups, each with an associated maximum fee.

ASC Maximum Allowable Fee by Group Number (1)(2)

Group	Fee	Payment Method
1	$778.00	• Fee Based on Medicare Rate
2	$1,043.00	• Fee Based on Medicare Rate
3	$1,192.00	• Fee Based on Medicare Rate
4	$1,473.00	• Fee Based on Medicare Rate
5	$1,676.00	• Fee Based on Medicare Rate
6	$1,730.00	• Fee Based on Medicare Rate
7	$2,326.00	• Fee Based on Medicare Rate
8	$2,074.00	• Fee Based on Medicare Rate
9	$3,130.00	• Fee Based on Medicare Rate
10	$4,800.00	• Max Fee, CPT® Code 63030
11	BR	• BR – Codes allowed in APC not on ASC List
12	BR	• BR – HCPCS
13	BR	• BR – Codes considered inpatient by CMS
14	Max Fee	• Max Fee (e.g., CPT® Codes 72240, 76005 or L8603), Radiology.

(1) Some services that do not belong to a payment group have a maximum fee. Other allowed services that are not part of a payment group are paid BR.

(2) Payment groups and rates for allowed procedures are listed in the Ambulatory Surgery Center Fee Schedule.

BRAIN INJURY REHABILITATION SERVICES

Only programs accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF) may provide post-acute brain injury rehabilitation services for injured workers. These services require prior authorization. Follow-up care is included in the cost of the full day or half-day program. This includes but is not limited to telephone calls, home visits and therapy assessments. See Provider Bulletins 98-02 and 98-04 for more information.

Non-hospital based programs must bill the following local codes:

Code	Description	Maximum Fee
8950H	Comprehensive brain injury evaluation	$ 3,664.77
8951H	Post-acute brain injury rehabilitation full day program, per day (minimum of 6 hours per day)	$ 654.42
8952H	Post-acute brain injury rehabilitation half day program, per day (minimum 4 hours per day)	$ 392.66

Hospital based programs must bill the following local revenue codes:

Code	Description	Maximum Fee
0014	Comprehensive brain injury evaluation	$ 3,664.77
0015	Post-acute brain injury rehabilitation full day program, per day (minimum of 6 hours per day)	$ 654.42
0016	Post-acute brain injury rehabilitation half day program, per day (minimum 4 hours per day)	$ 392.66

NURSING HOME, RESIDENTIAL AND HOSPICE CARE SERVICES

NURSING HOME AND RESIDENTIAL CARE

The department will only pay the following types of residential service providers:

- DSHS-licensed nursing homes
- DSHS-licensed and certified nursing facilities
- DSHS-licensed and certified skilled nursing facilities
- DSHS-licensed boarding homes
- DSHS-licensed and certified Adult Family Homes
- Special department-approved arrangements

Providers must obtain a separate provider number for each type of service provided. The insurer, on a case-by-case basis depending on the worker's needs, may approve group homes and other residential care settings. Assisted living services are not covered.

Adult Day Care service providers must individually bill the department using their individual provider numbers for services provided to injured workers. In order to be authorized by the department as a provider of Adult Day Care services to injured workers, the provider must furnish the department with a copy of the letter from DSHS approving the provider's status as an Adult Day Care provider.

HOSPICE CARE

L&I will only pay DSHS-licensed hospice care providers. Medically necessary skilled nursing care and custodial care are covered for the worker's accepted industrial injury or illness. Daily rate fees are negotiated between the facility and the insurer based on the Medicare rates for services provided. Occupational, physical and speech therapies are included in the daily rate and are not separately payable. Pharmacy and DME are payable when billed separately using appropriate HCPCS codes.

Programs must bill the following local codes:

Code	Description	Maximum Fee
8902H	Nursing home or Residential Care	BR
8906H	Facility hospice care	BR

Inappropriate use of CPT® and HCPCS codes may delay payment. For example, billing for drugs or physical therapy using DME codes is an example of improper coding and will delay reimbursement while the claim is being investigated.